

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/26/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155716		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/24/2015	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME HEALTH CENTER AND RESIDENTIAL				STREET ADDRESS, CITY, STATE, ZIP CODE 601 N BOEKE RD EVANSVILLE, IN 47711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00162860.</p> <p>Complaint IN00162860 - Unsubstantiated, due to lack of evidence.</p> <p>Survey dates: February 23 and 24, 2015</p> <p>Facility number: 000439 Provider number: 155716 AIM number: 100275070</p> <p>Survey team: Anne Marie Crays, RN-TC</p> <p>Census bed type: SNF: 21 NF: 36 SNF/NF: 112 Residential: 10 Total: 179</p> <p>Census payor type: Medicare: 20 Medicaid: 114 Other: 35 Total: 169</p> <p>Sample: 4</p> <p>Good Samaritan Home Health Center & Rehabilitation was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.1-3.1 in regard to the Investigation of Complaint IN00162860.</p>			F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 Quality Review 02/25/15 by Lisa McColly	F 000			